(4) Council for Affordable Quality Healthcare (CAQH) Phase III Committee on Operating Rules for Information Exchange (CORE) EFT & ERA Operating Rule Set, Approved June 2012, as specified in this paragraph and referenced in § 162.1603.

(i) Phase III CORE 380 EFT Enrollment Data Rule, version 3.0.0, June 2012.

(ii) Phase III CORE 382 ERA Enrollment Data Rule, version 3.0.0, June 2012.

(iii) Phase III 360 CORE Uniform Use of CARCs and RARCs (835) Rule, version 3.0.0, June 2012.

(iv) CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule, version 3.0.0, June 2012.

(v) Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule, version 3.0.0, June 2012.

(vi) Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule, version 3.0.0, June 2012, except Requirement 4.2 titled ''Health Care Claim Payment/Advice Batch Acknowledgement Requirements''.

(d) The National Automated Clearing House Association (NACHA), The Electronic Payments Association, 1350 Sunrise Valle Drive, Suite 100, Herndon, Virginia 20171 (Phone) (703) 561–1100; (Fax) (703) 713–1641; Email: *info@nacha.org;* and Internet at *http:// www.nacha.org.* The implementation specifications are as follows:

(1) 2011 NACHA Operating Rules & Guidelines, A Complete Guide to the Rules Governing the ACH Network, NACHA Operating Rules, Appendix One: ACH File Exchange Specifications (Operating Rule 59) as referenced in § 162.1602.

(2) 2011 NACHA Operating Rules & Guidelines, A Complete Guide to the Rules Governing the ACH Network, NACHA Operating Rules Appendix Three: ACH Record Format Specifications (Operating Rule 78), Part 3.1, Subpart 3.1.8 Sequence of Records for CCD Entries as referenced in § 162.1602.

[68 FR 8396, Feb. 20, 2003, as amended at 69 FR 18803, Apr. 9, 2004; 74 FR 3324, Jan. 16, 2009; 76 FR 40495, July 8, 2011; 77 FR 1590, Jan. 10, 2012; 77 FR 48043, Aug. 10, 2012]

§ 162.923 Requirements for covered entities.

(a) *General rule.* Except as otherwise provided in this part, if a covered entity conducts, with another covered entity that is required to comply with a transaction standard adopted under this part (or within the same covered entity), using electronic media, a transaction for which the Secretary has adopted a standard under this part, the covered entity must conduct the transaction as a standard transaction.

(b) *Exception for direct data entry transactions.* A health care provider electing to use direct data entry offered by a health plan to conduct a transaction for which a standard has been adopted under this part must use the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirements of the standard.

(c) *Use of a business associate.* A covered entity may use a business associate, including a health care clearinghouse, to conduct a transaction covered by this part. If a covered entity chooses to use a business associate to conduct all or part of a transaction on behalf of the covered entity, the covered entity must require the business associate to do the following:

(1) Comply with all applicable requirements of this part.

(2) Require any agent or subcontractor to comply with all applicable requirements of this part.

[65 FR 50367, Aug. 17, 2000, as amended at 74 FR 3325, Jan. 16, 2009]

§ 162.925 Additional requirements for health plans.

(a) *General rules.* (1) If an entity requests a health plan to conduct a transaction as a standard transaction, the health plan must do so.

(2) A health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the

transaction, because the transaction is a standard transaction.

(3) A health plan may not reject a standard transaction on the basis that it contains data elements not needed or used by the health plan (for example, coordination of benefits information).

(4) A health plan may not offer an incentive for a health care provider to conduct a transaction covered by this part as a transaction described under the exception provided for in § 162.923(b).

(5) A health plan that operates as a health care clearinghouse, or requires an entity to use a health care clearinghouse to receive, process, or transmit a standard transaction may not charge fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction to, or from, a health plan.

(6) During the period from March 17, 2009 through December 31, 2011, a health plan may not delay or reject a standard transaction, or attempt to adversely affect the other entity or the transaction, on the basis that it does not comply with another adopted standard for the same period.

(b) *Coordination of benefits.* If a health plan receives a standard transaction and coordinates benefits with another health plan (or another payer), it must store the coordination of benefits data it needs to forward the standard transaction to the other health plan (or other payer).

(c) *Code sets.* A health plan must meet each of the following requirements:

(1) Accept and promptly process any standard transaction that contains codes that are valid, as provided in subpart J of this part.

(2) Keep code sets for the current billing period and appeals periods still open to processing under the terms of the health plan's coverage.

[65 FR 50367, Aug. 17, 2000, as amended at 74 FR 3325, Jan. 16, 2009]

§ 162.930 Additional rules for health care clearinghouses.

When acting as a business associate for another covered entity, a health care clearinghouse may perform the following functions:

(a) Receive a standard transaction on behalf of the covered entity and translate it into a nonstandard transaction (for example, nonstandard format and/or nonstandard data content) for transmission to the covered entity.

(b) Receive a nonstandard transaction (for example, nonstandard format and/or nonstandard data content) from the covered entity and translate it into a standard transaction for transmission on behalf of the covered entity.

§ 162.940 Exceptions from standards to permit testing of proposed modifications.

(a) *Requests for an exception.* An organization may request an exception from the use of a standard from the Secretary to test a proposed modification to that standard. For each proposed modification, the organization must meet the following requirements:

(1) *Comparison to a current standard.* Provide a detailed explanation, no more than 10 pages in length, of how the proposed modification would be a significant improvement to the current standard in terms of the following principles:

(i) Improve the efficiency and effectiveness of the health care system by leading to cost reductions for, or improvements in benefits from, electronic health care transactions.

(ii) Meet the needs of the health data standards user community, particularly health care providers, health plans, and health care clearinghouses.

(iii) Be uniform and consistent with the other standards adopted under this part and, as appropriate, with other private and public sector health data standards.

(iv) Have low additional development and implementation costs relative to the benefits of using the standard.

(v) Be supported by an ANSI-accredited SSO or other private or public organization that would maintain the standard over time.

(vi) Have timely development, testing, implementation, and updating procedures to achieve administrative simplification benefits faster.

(vii) Be technologically independent of the computer platforms and transmission protocols used in electronic